MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83a

68989

CERTIFICATE OF DEATH

Reg. Dist. No. 100

1. PLACE OF DEATH:

County: Charles

City or town: La Plata

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, Institution, or street address where death occurred: Physicians Memorial Hospital

How long in hospital or institution? 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Charles

City or town: La Plata

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Robert Henry Barnes

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro	Married

6.(b) Name of husband or wife: Gertrude Sylas Barnes

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 1869 - 1871

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
76-78	?	?		

9. Birthplace: La Plata, Charles, Md. (Town, county, and state)

10. Usual occupation: Truck driver

11. Industry or business: Grocery store

FATHER — 12. Name: Charles Barnes

FATHER — 13. Birthplace:

MOTHER — 14. Maiden name: Adeline —

MOTHER — 15. Birthplace:

16. Informant: Charles Barnes (son)

Address: La Plata, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10-5-47 (month) (day) (year)

Cemetery or crematory: New Town

Location: Route La Plata MD

18. Funeral director: Hunt & Regan

Address: Waldorf Md

19. 10-6 1947 Julia H. Posey (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 2, 1947 at 7'5 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 24, 1947, to Oct. 2, 1947

and that I last saw him alive on Oct. 1, 1947

	DURATION
Immediate cause of death: Cerebral hemorrhage	8 days
Due to: Generalized arteriosclerosis	?
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: — Date of op.

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: James L. MacKaracough, M.D. M. D. or other

Address: La Plata, Md. Date signed 10-2-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct date is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

68990

93d

Reg. Diat. No. 100

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Charles
City or town: La Plata, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED.
(For newborn infants give residence of mother)
State: Md. County: Charles
City or town: La Plata
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME KATHRYN BERRY

3.(b) Social Security Number

4. Sex: F
5. Color or race: W
6.(a) Single, married, widowed, or divorced: Widowed
6.(b) Name of husband or wife: Edward Berry
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): July 14, 1874
8. AGE: Years: 73 Months: 3 Days: 3 If less than one day: hrs. min.
9. Birthplace: La Plata, Md. (town, county, and state)
10. Usual occupation: Housework
11. Industry or business:
FATHER 12. Name: Samuel Hawkins
13. Birthplace: Bel Alton, Md.
MOTHER 14. Maiden name: Jane Robertson
15. Birthplace: Md.
16. Informant: Mrs Olga Lenering
Address: La Plata, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 10/19/47 (month) (day) (year)
Cemetery or crematory: St. Pauls
Location: Rural, Waldorf, Md.
18. Funeral director: Hunt & Ryon
Address: Waldorf, Md.
19. 10-19 (Date rec'd by registrar) 19 47 Julia H. Posey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 17 19 47 at 12:55 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 17 19 47, to Oct. 17 19 47 and that I last saw her alive on Oct. 16 19 47

Immediate cause of death: Congestive Heart Failure — DURATION

Due to: Arteriosclerotic Cardiovascular Disease

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Warren Jarboe M.D.
M. D. or other
Address: La Plata, Md. Date signed: 10-17-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

13/a

68991

Reg. Dist. No. 195

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS-A15 9-45-15M

1. PLACE OF DEATH

County: Charles

City or town: Waldorf Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 24

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Charles

City or town: Mellwood

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME John Pliny Bonwell

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife: Lillian

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.) 5/7 15-1878

8. AGE: Years: 69 | Months: | Days: 28 | If less than one day: hrs. min.

9. Birthplace: Accomac Va (Town, county, and state)

10. Usual occupation: Ret

11. Industry or business

FATHER 12. Name: Joseph Bonwell

13. Birthplace: Accomac Md

MOTHER 14. Maiden name: Anne Adams

15. Birthplace: Accomac Md

16. Informant: Lillian Bonwell

Address: Waldorf Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 10-16-47 (month) (day) (year)

Cemetery or crematory: St Marys

Location: Piscataway Md

18. Funeral director: Smith & Gray

Address: Waldorf Md

19. 10-15 1947 (Date rec'd by registrar) M. L. Mowen Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 10 | 13 | 1947, at 4 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 6 | 14 | 1947, to 10 | 13 | 1947

and that I last saw h... alive on 10 | 13 | 1947

	DURATION
Immediate cause of death: Cerebral Thrombosis	
Due to: Cardio-Vas. Renal Disease	
Due to: Senility	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Geo. D. Wadsworth M.D. M. D. or other

Address: Waldorf Md Date signed 10/14/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

114e

68992

Reg. Dist. No. 103

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Charles

City or town: Newport

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7½ mos

Hospital, Institution, or street address where death occurred: —

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Charles

City or town: Newport

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Joseph Jerom Cooper

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.) March 9, 1947

8. AGE:

Years	Months	Days	If less than one day
0	7	19	... hrs. ... min.

9. Birthplace: Newport, Charles, Md. (Town, county, and state)

10. Usual occupation: Infant

11. Industry or business

FATHER

12. Name: Thos Arthur Cooper

13. Birthplace: Newport, Md.

MOTHER

14. Maiden name: Mary Gertrude Cole

15. Birthplace: Newport, Md

18. Informant: Thos A. Cooper (father)

Address: Newport, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 29, 1947 (month) (day) (year)

Cemetery or crematory: St. Mary's Cemetery

Location: Newport, Md.

18. Funeral director: Wm Cole (acting)

Address: Newport, Md

19. Oct. 29 1947 (Date rec'd by registrar) Mary E. Burch. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 25 1947 at 2:30 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from on Oct. 25 1947, to ... 19... and that I last saw h. alive on Oct. 25 1947

Immediate cause of death	DURATION
Acute respiratory infection	2-3 wks
Due to: Undiagnosed	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. —

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury ... Injured at work?

23. SIGNATURE: James L. MacKaumagh, M.D. Deputy Medical Examiner

M. D. or other

Address: La Plata, Md. Date signed 10-25-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

510 08993

CERTIFICATE OF DEATH

Reg. Diat. No. 100

1. PLACE OF DEATH:
County: Charles
City or town: Newburg
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants, give residence of mother)
State: Md. County: Charles
City or town: Newburg
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME William Coulby

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Widowed

6.(b) Name of husband or wife
6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.): July 8, 1867

8. AGE: Years 80 | Months 3 | Days 9 | If less than one day ... hrs. ... min.

9. Birthplace: Calvert Co. Md.
(Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business

FATHER
12. Name: John Robert Coulby
13. Birthplace: Md.

MOTHER
14. Maiden name: Mary ann Morris
15. Birthplace: Ireland

16. Informant: Edgar Coulby
Address: Newburg, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10/19/47 (month) (day) (year)
Cemetery or crematory: Christ Church
Location: Wayside, Md.

18. Funeral director: Hebert & Ryon
Address: Waldorf Md.

19. 10-19 19 47 (Date rec'd by registrar) Julia H. Posey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 10-17 19 47 at 5 30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from V-11 19 40 to 10-17 19 47 and that I last saw him alive on 10-17 19 47

	DURATION
Immediate cause of death: Carcinoma Prostate	5-10-46
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: E Hodelin M. D.
M. D. or other
Address: La Plata Md. Date signed 10-18-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

08994

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

170c

CERTIFICATE OF DEATH

Reg. Dist. No. 101

1. PLACE OF DEATH:
County: Charles
City or town: Marbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Charles
City or town: Chicamuxen.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: World War II

3. (a) FULL NAME: James Calvin Davis

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Col.	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 12 1925

8. AGE: Years: 22 | Months: 7 | Days: 3 | If less than one day: hrs. min.

9. Birthplace: Chicamuxen, Md.
(Town, county, and state)

10. Usual occupation: Laborer.

11. Industry or business: Contractor.

FATHER
12. Name: Richard B. Davis
13. Birthplace: Chicamuxen, Md.

MOTHER
14. Maiden name: Elizabeth Smallwood
15. Birthplace: Chicamuxen, Md.

16. Informant: Richard Davis
Address: Chicamuxen, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 22 1947 (month) (day) (year)
Cemetery or crematory: Alexander M.E. Church.
Location: Chicamuxen, Md.

18. Funeral director: Penny & Cofer
Address: Mason Springs, Md.

19. Oct. 22 1947 (Date rec'd by registrar) Mary Swillenlund Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 19 1947 approx. at 3A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

	DURATION
Immediate cause of death: Ruptured Heart, Left Lung, Liver, Right Kidney, result of auto accident (Hit & Run)	
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results: See Above (Immed. Cause of Death)
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of: 10-19-47
Where did injury occur? Marbury (City or town) Charles (County) Md (State)
Injured at home, farm, industry, public place (where?): Md #4 Hwy 224
Means of injury: Automobile Injured at work? No.

23. SIGNATURE: Frank G. Susan G. S. M. D. or other
Address: Faber Head. Md. Date signed: 10-20-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

108

08995

CERTIFICATE OF DEATH

Reg. Diat. No. 105

1. PLACE OF DEATH:

County: Charles

City or town: La Plata

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4-5 yrs.

Hospital, institution, or street address where death occurred: Physicians Memorial Hospital

How long in hospital or institution? 24 hrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Charles

City or town: La Plata

(If outside city or town limits, write RURAL and give nearest town)

Street No.:

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: William Albert Gibbs

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): December 3 ?

8. AGE: Years: 29? Months: Days: If less than one day: hrs. min.

9. Birthplace: Chestertown, Md. (Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business:

FATHER 12. Name: unknown

13. Birthplace: "

MOTHER 14. Maiden name: unknown

15. Birthplace: "

16. Informant: Hospital Records

Address: La Plata Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11/1/47 (month) (day) (year)

Cemetery or crematory: St. Peters (Old cemetery)

Location: Waldorf, Md.

18. Funeral director: Hewitt & Ryon

Address: Waldorf, Md.

19. Nov 1 1947 M E Mozed (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 31, 1947, at 10:45 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 31 1947, to 19; and that I last saw him alive on Oct. 31, 1947

Immediate cause of death	DURATION
Acute Congestive heart failure	minutes
Due to: Toxic myocarditis	Weeks
Due to: Unresolved lobar pneumonia	Weeks
Other conditions: Ether anesthesia	2½ hr.

(Include pregnancy within 3 months of death)

Major findings of operations: Herniorrhaphy

Date of Op. 10-31-47

Autopsy results: Cf. above.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: John L. MacKavanagh, M.D. M. D. or other

Address: La Plata, Md. Date signed 10-31-47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83a

68996

CERTIFICATE OF DEATH

Reg. Diat. No. 100

1. PLACE OF DEATH:
County: Charles
City or town: La Plata
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred: Physicians' Memorial Hospital
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Charles
City or town: La Plata
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: John Paul Hancock

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife: Margaretta
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): June 29 1896

8. AGE: Years 51 | Months | Days | If less than one day ..... hrs. ..... min.

9. Birthplace: Washington D C (Town, county, and state)

10. Usual occupation: Retired Merchant

11. Industry or business

FATHER — 12. Name: John W. Hancock
13. Birthplace: Bel Alton Md

MOTHER — 14. Maiden name: Mary
15. Birthplace: Virginia

16. Informant: Margaretta Hancock
Address: La Plata Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10-18-47 (month) (day) (year)
Cemetery or crematory: Mt. Rest
Location: La Plata, Md

18. Funeral director: Hyatt & Ryon
Address: La Plata Md

19. 10-18 19 47 (Date rec'd by registrar) Julia H. Posey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 16 October 19 47 at 2:21 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 19 47 to 16 October 19 47 and that I last saw h.im alive on 16 October 19 47

Immediate cause of death	DURATION
Intracranial hemorrhage	4 days.
Due to: Cerebral - vascular accident.	4 days.
Due to: Hypertension	3 years.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: None. Date of op.

Autopsy results: None.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: A B Woods M.D.
M. D. or other
Address: La Plata, Maryland Date signed 16 Oct 47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

46e

69504
105

Reg. Diat. No. .....

1. PLACE OF DEATH:

County ..... Charles.

City or town ..... Pomfret

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? ..... 30 yrs.

Hospital, institution, or street address where death occurred:

.....

How long in hospital or institution? ..... Charlotte Sandy

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State ..... Md. County ..... Charles

City or town ..... Pomfret

(If outside city or town limits, write RURAL and give nearest town)

Street No. .....

(If rural, give LOCATION)

2.(a) If veteran, name war .....

3. (a) FULL NAME Lottie Hemsley

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Col	Married

6.(b) Name of husband or wife ..... Fred Hemsley

6.(c) If alive, give age ..... 56 ..... years

7. Birth date of deceased (mo., day, yr.) ..... March 2. 1877

8. AGE: Years 70 | Months 7 | Days 7 | If less than one day ..... hrs. ..... min.

9. Birthplace ..... Charles County Md

(Town, county, and state)

10. Usual occupation ..... Housewife

11. Industry or business ..... Own Home

FATHER

12. Name ..... Emmis Brooks

13. Birthplace ..... ? (Md).

MOTHER

14. Maiden name ..... Martha Bell

15. Birthplace ..... ? (Md).

16. Informant ..... Fred Hemsley

Address ..... Pomfret

17. ..... Burial ..... Date thereof ..... Oct 11 1947

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory ..... St Joseph Cath Cem

Location ..... Pomfret

18. Funeral director ..... Hunt & Ryan

Address ..... Welcby Md

19. ..... Oct 10 ..... 19 ..... M L Howard

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH ..... Oct 9 ..... 19 47 ..... at 4:30 A. M.

21. I CERTIFY that death occurred on the date above stated, that I attended deceased from May 2, 19 47 to Oct. 9 19 47 and that I last saw h.er alive on Oct. 8 19 47

Immediate cause of death	DURATION
Carcinoma descending Colon	4 mos.
Due to	
Due to	
Other conditions Chronic Myocarditis	2yrs.

(Include pregnancy within 3 months of death)

Major findings of operation ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE ..... Fred L. Swan M. D.

M. D. or other

Address ..... Indian Head, Md. Date signed 10-9-47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

CERTIFICATE OF DEATH

08997

Reg. Diat. No. 100

1. PLACE OF DEATH:
County: Charles
City or town: La Plata
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Physicians' Memorial Hospital
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Charles
City or town: Bryantown
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: BENJAMIN MASON

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	C	widowed

6.(b) Name of husband or wife: Margaret Turner
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): 1867

8. AGE: Years: 80 Months: Days: If less than one day: hrs. min.

9. Birthplace: St Marys Co, Md (Town, county, and state)

10. Usual occupation: Retired Laborer

11. Industry or business

FATHER 12. Name: Nat Thomas
13. Birthplace

MOTHER 14. Maiden name: Nat Thomas
15. Birthplace

16. Informant: St Mary Co Welfare Bd
Address: Leonardtown

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10/17/47 (month) (day) (year)
Cemetery or crematory: St Marys
Location: Bregandtown

18. Funeral director: Elmer E. Howard
Address: Hughesville Md

19. 10-17 19 47 (Date rec'd by registrar) Julia H. Posey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 15 19 47 at 9 30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10-1 19 47 to 10-15 19 47 and that I last saw h.e.r. alive on 10-15 19 47

Immediate cause of death	DURATION
ARTERIOSCLEROTIC HEART DISEASE	UNKNOWN
Due to: GENERALIZED ARTERIO-SCLEROSIS	UNKNOWN
Due to:	
Other conditions: BENIGN PROSTATIC HYPERTROPHY	1 YEAR

(Include pregnancy within 3 months of death)

Major findings of operations: — Date of op. —

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: —
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: John H. Griffin, M.D. M. D. or other
Address: Hughesville, Md. Date signed 10-16-47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

08998

Birth + Death 159

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF ~~STILLBIRTH~~

Reg. Dist. No. 100

A certificate must be filed within 24 hours for every stillbirth of 20 weeks' gestation or more (see stub)

1. PLACE OF BIRTH:
   County: Charles
   City or town: La Plata
   (If outside city or town limits, write RURAL and give nearest town)
   Street address, hospital, or institution: Physicians Memorial Hospital
   Length of mother's stay in County:
   (How many years, or months, or days. SPECIFY WHICH)

2. USUAL RESIDENCE OF MOTHER:
   State: Maryland
   County: Charles
   City or town: La Plata
   (If outside city or town limits, write RURAL and give nearest town)
   Street No.:
   (If RURAL give LOCATION)

3. Name of child:

4. Date of birth: Oct. 13 1947 Hour: M.

5. Sex: Male | 6. Twin or triplet: —

7. No. of weeks pregnancy: 20-24

FATHER OF CHILD

8. Full name: Bart Miller

9. Color: W. 10. Age at time of this birth: 42 yrs.

11. Usual occupation: Welder

MOTHER OF CHILD

12. Full maiden name: Ellen Marguerite Della

13. Color: W. 14. Age at time of this birth: 24 yrs.

15. Usual occupation: Wife

16. Other children born to mother (not including present child): (a) How many children of this mother are now living? 0
(b) How many other children were born alive but are now dead? 0 (c) How many other children were *born* dead? 0

17. Did child die before labor? No During labor? No

18. Pregnancy, complications of: None

19. Labor: (a) Complications of: None
(b) Induced? No

20. (a) Was there an operation for delivery? No (Yes or No)
(b) State all operations, if any: —
(c) Did child die before operation?
During operation?

21. Cause of stillbirth. Please be specific. For terms like prematurity, asphyxia, etc., try to add cause thereof.
(a) Fetal causes: Prematurity - 20-24 wks
(b) Maternal causes: None known

22. I certify to the birth of this child who was born ~~dead*~~ alive on the date and hour above stated.
Signature: James L. MacKavanagh, M.D.
(Specify if M. D., midwife, or other)
Address: La Plata, Md.

23. (a) Burial (Burial, cremation or removal) (b) Date thereof 10-13-47 (month) (day) (year)
(c) Cemetery or crematory: Peerless Home-La Plata

24. (a) Funeral director: Bart Miller (Father)
(b) Address: La Plata, Md.

25. (a) 10-13-47 (Date rec'd by registrar) (b) Julia H. Posey (Registrar)

26. (To be filled out if no physician was present at delivery.) The above certificate has been examined by me.
Health Officer, per

* See Instruction C on stub.

Child lived 30 minutes

(I)

Job. to Bartholow

V. S. A10

(T)

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

932 08999

CERTIFICATE OF DEATH

Reg. Dist. No. 100

1. PLACE OF DEATH:

County: Charles

City or town: La Plata

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Physicians' Memorial Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Charles

City or town: La Plata

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Robert Guy Monroe

3.(b) Social Security Number:

4. Sex	5. Color or race	7.(a) Single, married, widowed, or divorced
M.	W.	S.

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Nov. 24, 1880

8. AGE:

Years	Months	Days	If less than one day
66	10	14	..... hrs. ..... min.

9. Birthplace: Charles County, Md. (Town, county, and state)

10. Usual occupation: Printer

11. Industry or business

FATHER — 12. Name: John Robert Monroe

FATHER — 13. Birthplace: Chas. Co.

MOTHER — 14. Maiden name: Elizabeth Ann Dove

MOTHER — 15. Birthplace: Charles Co., Md

16. Informant: Mrs. Selman Lines

Address: La Plata, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10-10-47 (month) (day) (year)

Cemetery or crematory: St. Pauls

Location: Piney, Md

18. Funeral director: Hewitt & Ryon

Address: Waldorf, Md

19. 10-9 19 47 (Date rec'd by registrar) Julia H. Pacey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 10-8 19 47 at 1:36 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9-24 19 47 to 10-8 19 47 and that I last saw h.. l.. alive on 10-8 19 47

Immediate cause of death	DURATION
Cerebral Hemorrhage	9-24-47
Due to: Hypertensive Heart Disease	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: ..... Injured at work?

23. SIGNATURE: [signature] M.D. (M.D. or other)

Address: La Plata Md Date signed 10-8-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

93d

Reg. Dist. No. 100

1. PLACE OF DEATH

County: Charles

City or town: Rural (Marshall's Corner)

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Charles

City or town: Marshall's Corner

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Pomfret P.O.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Ida Pryor

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	C	M.

6.(b) Name of husband or wife: Charles Pryor

6.(c) If alive, give age: 70 years

7. Birth date of deceased (mo., day, yr.):

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
64				

9. Birthplace: Chas. Co. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER — 12. Name: Wm Hawkins

13. Birthplace: Charles

MOTHER — 14. Maiden name: Harriet Smith

15. Birthplace: Charles Co.

16. Informant: Charles Pryor

Address: La Plata, (Md R.F.)

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10-24-47 (month) (day) (year)

Cemetery or crematory: St. Joseph's

Location: Pomfret, Md.

18. Funeral director: Stanley Penney

Address: Mason Springs, Md.

19. 10-22 19 47 (Date rec'd by registrar) Julia A. Penney Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 21 19 47 at 8 45 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 19 19 47 to Oct 21 19 47

and that I last saw h[illegible] alive on Oct 20 19 47

Immediate cause of death	DURATION
Cerebral Hemorrhage	(10-21-47)
Due to: Hypertension & Vascular Disease	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?):

Means of injury: Injured at work?

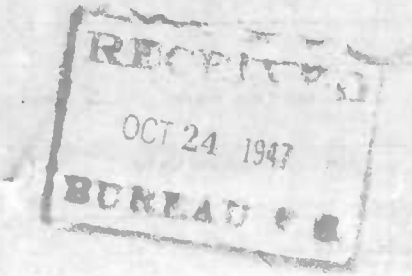
23. SIGNATURE: [illegible] M. D. (R.) M. D. or other

Address: La Plata, Md. Date signed (10-22-47)

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING


OCT 24 1947

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

69001

157f

Reg. Dist. No. 105

1. PLACE OF DEATH:

County: Charles

City or town: Hughesville Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 74 yrs

Hospital, institution, or street address where death occurred: No

How long in hospital or institution? 2

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Charles

City or town: Hughesville

(If outside city or town limits, write RURAL and give nearest town)

Street No. ✓

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Ruth alice Richardson

3.(b) Social Security Number: No

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	M

6.(b) Name of husband or wife: Andrew Jerome Richardson

Married 12 6.(c) If alive, give age 52 years

7. Birth date of deceased (mo., day, yr.): [illegible] 1895

8. AGE: Years 52 Months 7 Days 9 If less than one day ..... hrs. ..... min.

9. Birthplace: Mulberry Md (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Home

FATHER 12. Name: Geo W Adams

13. Birthplace: Balto Md

MOTHER 14. Maiden name: Mary Virginia Robey

15. Birthplace: Port Tobacco Md

16. Informant: Andrew Jerome Richardson

Address: Hughesville Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 24/47 (month) (day) (year)

Cemetery or crematory: Emanuel Md

Location: Loden Md

18. Funeral director: Brown Bros

Address: 8406 Alaska Ave N.W.

19. Oct 23 1947 (Date rec'd by registrar) M L Howell Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 21 — 19 47, at 7:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 23 19 47, to October 20 19 47

and that I last saw h.. alive on September 8 19 47

Immediate cause of death	DURATION
HEMORRHAGE, CEREBRAL, RIGHT	11 MONTHS
Due to: CONGENITAL ARTERIAL ANEURYSM	—
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op. —

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: John H. Griffin, M.D.

M. D. or other

Address: Hughesville, Md. Date signed 10-23-47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

NAME OF DECEASED changed to VIRGINIA by new cer signed by Dr Higdon, plus letter from local registrar, filmed

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10-28-47 G113-LL

CERTIFICATE OF DEATH

162b

Reg. Dist. No. 104

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:
County: Charles
City or town: Issue
(If outside city or town limits, write RURAL and give nearest towe)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Charles 03002
City or town: Issue
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME ~~Virginia~~ VIRGINIA Short

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Black	Widowed

6.(b) Name of husband or wife: Unknown
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): 1854

8. AGE: Years: 93 Months: Unknown Days: If less than one day ..... hrs. ..... min.

9. Birthplace: Virginia (Towe, county, and state)
10. Usual occupation: Housewife
11. Industry or business
FATHER 12. Name: James Connick
13. Birthplace: Virginia
MOTHER 14. Maiden name: Unknown
15. Birthplace
16. Informant: Bruce Templeman
Address: Issue, Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof 10/17/47 (month) (day) (year)
Cemetery or crematory: Holy Ghost Cemetery
Location: Issue, Md
18. Funeral director: Hewitt and Ryon
Address: Waldorf, Md
19. 10/17 1947 W. Ellen Frere Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 15, 1947, at ..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct Sept 2 1947, to Oct. 15 1947
and that I last saw h.. alive on Sept 2 1947

Immediate cause of death	DURATION
Advanced age	
Due to: Senile debility	45 days
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major fiodiogs of operations: ..... Date of op. .....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ..... Injured at work?

23. SIGNATURE: T. L. Heydon M. D. or other
Address: Bryantown Date signed Oct 17, 47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

185

CERTIFICATE OF DEATH

Reg. Diat. No. 09063

1. PLACE OF DEATH:

County: Charles

City or town: LaPlata

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? en route to hospital

Hospital, institution, or street address where death occurred:

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Charles

City or town: Charlotte Hall P.O.

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Dentsville

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME James Carroll Spaulding

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mary

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): Oct. 5, 1895

8. AGE: Years: 52 | Months: | Days: 8 | If less than one day: ____ hrs. ____ min.

9. Birthplace: Lenardtown, Md (Town, county, and state)

10. Usual occupation:

11. Industry or business: Saw Mill

FATHER — 12. Name: Edward Leo Spaulding

FATHER — 13. Birthplace: Lenardtown, Md.

MOTHER — 14. Maiden name: Mary E. Gatton

MOTHER — 15. Birthplace: Lenardtown, Md.

16. Informant: Mrs Mary Spaulding (wife)

Address: Dentsville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 10/15/47 (month) (day) (year)

Cemetery or crematory: St. Georges

Location: Valley Lee, Md.

18. Funeral director: Hunt & Ryon

Address: Waldorf, Md.

19. Oct 14 1947 (Date rec'd by registrar) M. L. Monroe Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 13 1947 at 5-25-30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased on October 13, 1947 to ____ 19__ and that I saw h... on October 13, 1947

Immediate cause of death	DURATION
Exsanguination	[redacted]
Due to: Lacerated wound rt. axillary artery	2½ hr.
Due to: Accident	2½ hr.
Other conditions: Cerebral hemorrhage with hemiplegia (Include pregnancy within 3 months of death)	One yr.

Major findings of operations: ____ Date of op. ____

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of: 10-13-47

Where did injury occur? Dentsville, (City or town) Charles, (County) Md (State)

Injured at home, farm, industry, public place (where?): Home

Means of injury: Fell on bottle Injured at work? No

Deputy Medical Examiner

23. SIGNATURE: James L. McKaraugh, M.D. M. D. or other

Address: LaPlata, Md. Date signed: 10-13-47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09004

480

CERTIFICATE OF DEATH

Reg. Dist. No. 104

1. PLACE OF DEATH:

County: Charles

City or town: Wayside

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Charles

City or town: Wayside

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Dr. Ray Washington

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Col.	Married

8.(b) Name of husband or wife: Monroe Washington

8.(c) If alive, give age: 37 years

7. Birth date of deceased (mo., day, yr.): March 21, 1922

8. AGE: Years: 25 | Months: 6 | Days: 13 | If less than one day: ... hrs. ... min.

8. Birthplace: Wayside - Charles - Md (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER — 12. Name: Thomas Coates

FATHER — 13. Birthplace: Wayside, Md

MOTHER — 14. Maiden name: Ida Matilda Barnes

MOTHER — 15. Birthplace: Wayside, Md

16. Informant: Monroe Washington

Address: Wayside, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct. 10, 1947 (month) (day) (year)

Cemetery or crematory: Shiloh Cemetery

Location: Wayside, Md

18. Funeral director: Hunter & Ryon

Address: Waldorf, Md.

19. 10/8 1947 (Date rec'd by registrar) William H. Hess Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 8 1947 at 7a. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 8 - 1947 to Oct 8 - 1947 and that I last saw h...s alive on Sept 2 - 1947

Immediate cause of death	DURATION
Cerebral Hemorrhage	10 min.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of ...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: ... Injured at work?

23. SIGNATURE: T. L. Hunter, M. D. or other

Address: Wayside, Md. Date signed: Oct 8 47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15